Type of Requestor:	(x) HCP ( ) IE (	) IC	<b>Response Timely Filed?</b> (x) Yes ( ) No				
Requestor's Name and A	Address		MDR Tracking No.: M4-04-4756-01				
7125 Marvin D. Love #	107		TWCC No.:  Injured Employee's Name:  Date of Injury:				
Dallas, TX 75237							
Respondent's Name and	Address						
Fidelity & Guaranty Inst	urance		Employer's Name:				
Box 19			Insurance Carrier	A36460067700010	A36460067700010164		
PART II: SUMMAI	RY OF DISPUTE AND	FINDINGS (Details on	Page 2, if needed)				
<b>Dates of Service</b>		CPT Code(s) or Description		Amount in Dispute	Amount Due		
From	To	- Ci i couc(s) of Description		Tanount in 2 ispute	7		
07/18/03	07/18/03	99204, 71020-WP & 80053		\$73.54			
PART III: REOUES	STOR'S POSITION SU	MMARY					
			ges were not paid acc	cording to TWCC Fee Schedule	,,,		
	DENT'S POSITION S	HMMARV					

CPT Code 99204 for date of service 07/18/03. The carrier reduced the reimbursement; but did not include a payment exception code. Per the 1996 MFG/E&M CPT descriptor the maximum allowable reimbursement is \$106.00; the insurance carrier reimbursed a total of \$78.65 leaving a balance of \$27.35 in dispute. Additional reimbursement in the amount of \$27.35 is recommended.

CPT Code 71020-WP for date of service 07/18/03. The carrier reduced reimbursement; but did not include a payment exception code. Per the 1996 MFG/R/NMGR CPT descriptor the maximum allowable reimbursement for both PC\$ and TC\$ is \$70.00; the insurance carrier reimbursed a total of \$48.98, leaving a balance of \$21.02 in dispute. Additional reimbursement in the amount of \$21.02 is recommended.

CPT Code 80053 for date of service 07/18/03. The carrier reduced reimbursement; but did not include a payment exception code. Per the 1996 MFG/PGR this CPT code is not one of the pathology codes listed in the Fee Guideline; therefore, additional reimbursement is not recommended.

	Amount in	Amount	Date of		Amount in	Amount				
CPT Code	Dispute	Due	Service	CPT Code	Dispute	Due				
99204	\$27.35	\$27.35								
71020-WP	\$21.02	\$21.02					1			
80053	\$25.17	\$0.00					ı			
							,			
							1			
							•			
				Total l	Left Column:	\$73.54				
					Amount Due:	\$48.37	ı			
							ı			
PART VII: CO	MMISSION DECI	SION AND ORDE	ĊR.							
entitled to add this amount pl	itional reimburs	ement in the am	ount of \$48.37.	The Division h	w Division has dereby <b>ORDERS</b> tor within 20-day	the insurance c	arrier to remit			
Ordered by:										
Marguerit							12/17/04			
Author	rized Signature		Typed Name			Date of Order				
PART VIII: YO	OUR RIGHT TO R	EQUEST A HEAR	RING							
Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request. The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party										
involved in the dispute.  Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.										
PART IX: INSU	JRANCE CARRIE	ER DELIVERY CE	ERTIFICATION							
I hereby verify	that I received	a copy of this D	ecision and Ord	ler in the Austin	Representative'	s box.				
Signature of I	Signature of Insurance Carrier: Date:									
I			<del></del>							

PART VI: DETAIL FINDINGS (If needed)